No. 93-120

In The

Supreme Court of the United States

October Term, 1993

THOMAS JEFFERSON UNIVERSITY, d/b/a
THOMAS JEFFERSON UNIVERSITY HOSPITAL,

Petitioner,

v.

DONNA E. SHALALA, SECRETARY
OF HEALTH AND HUMAN SERVICES,

Respondent.

On Writ Of Certiorairi
To The United States Court Of Appeals
For The Third Circuit

BRIEF OF AMICI CURIAE STATES OF OHIO, ARKANSAS, DELAWARE, LOUISIANA, MINNESOTA, NEW HAMPSHIRE, NEW YORK, PENNSYLVANIA, UTAH AND VIRGINIA IN SUPPORT OF PETITIONER

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ISSUE PRESENTED

Whether 42 C.F.R. § 413.85 allows providers to receive reimbursement for a fair share of all direct and indirect costs related to educational activities customarily or traditionally carried on by providers in conjunction with their operations.

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INTEREST OF AMICI CURIAE

The States that have joined this brief as amici curiae have a substantial interest in the outcome of this litigation. Each operates a Medicare-approved graduate medical education program ("GME program") for interns and residents in affiliation with an existing college of medicine. Each is entitled to receive reimbursement from Medicare for costs related to the GME program.

The Third Circuit Court of Appeals has affirmed a lower court decision holding that hospitals which conduct GME programs in conjunction with an existing college of medicine are precluded from recovering Medicare reimbursement for any indirect costs incurred by such programs if they have failed to seek reimbursement of these costs prior to 1985. In contrast, teaching hospitals which conduct their GME programs with their own staff and facilities are routinely permitted to recover these indirect costs. The Third Circuit's decision cannot be squared with existing law. If allowed to stand, the ruling will sanction discrimination against university hospitals and significantly impair the ability of such hospitals to provide interns and residents with the clinical experience necessary to meet the public's need for qualified physicians.

University hospitals have traditionally operated their GME programs through the use of the faculty, facilities, and other resources of existing educational units. It would be inefficient to require these hospitals to build new facilities and create new staffs when those resources are already in place. The operation of GME programs in

this common fashion is the most sensible and economical use of existing resources.

The effect of the Third Circuit's decision, however, is to penalize a select number of teaching hospitals – the majority of which are State institutions – as an extrastatutory means of streamlining the Medicare budget. But a regime that would preclude these hospitals from receiving Medicare reimbursement simply because they work in coordination with existing educational units would irrationally penalize the teaching hospitals for attempting to operate in the most efficient manner.

If health care reform is to become a reality, then the private and public health care sectors must continue to work together in close coordination to provide the medical education necessary to ensure the existence of a sufficient number of qualified practitioners. Quite simply, there is no authority for the Secretary to single out university-affiliated teaching hospitals, the majority of which are affiliated with State universities, and refuse to reimburse them for allowable costs related to their GME programs, simply as a unilateral method of reducing the Medicare budget. This unauthorized approach, moreover, is unfairly punitive, economically unsound, and directly undermines the ability of the States to continue to train individuals to become qualified health care practitioners.

SUMMARY OF ARGUMENT

The Third Circuit's judgment affirming the district court essentially holds that reimbursement of otherwise allowable indirect costs of a hospital's GME program will

be denied if those costs have not been claimed in the past. The Third Circuit's rationale is that it is always reasonable to assume that these costs were borne by the community simply because the hospital had not claimed reimbursement for them in the previous years. This decision is contrary to the plain language of the statute and regulations at issue and their legislative history as well as other relevant Medicare regulations.

42 C.F.R. § 413.85(c) recognizes the importance of Medicare's participation in training programs for health care professionals by providing reimbursement for the direct and indirect costs of a hospital's educational activities in such programs. 42 C.F.R. § 413.85(g) provides a specific formula for calculating the allowable costs of such programs. That formula includes all direct and indirect costs of the education program and deducts from total costs only those revenues received by the hospital from tuition.

42 C.F.R. § 413.85(c) also recognizes, as a general concept, that the community ultimately should bear the cost of such educational programs. The regulation does not define what constitutes community support or otherwise set an accounting standard by which such support can be quantified and deducted from the allowable costs of GME programs. The Secretary, however, has sought to elevate this general concept into an unjustified rule of law whereby revenues received from grants and state funding can be offset against the allowable *indirect* costs of these programs if such costs are incurred through the use of faculty, facilities, and other resources of a college of medicine.

In addition, the Third Circuit has misinterpreted the redistribution principle embodied in 42 C.F.R. § 413.85(c), which provides that although the Medicare program will "share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations," the program will not participate in "increased costs resulting from redistribution of costs from educational institutions . . . to patient care institutions." The Third Circuit has held that this principle means a provider must prove that it has historically incurred, paid, and reported GME costs in order to avoid the regulation's prohibition against redistributing costs from educational units to patient care units. In so doing, the Third Circuit has ignored the plain language of the regulation, which reflects that it is *the educational activities themselves* which must be customary and traditional, not the provider's practice of paying for them.

The Third Circuit's judgment also runs afoul of Medicare's requirement that costs must be properly allocated between Medicare and non-Medicare beneficiaries. 42 U.S.C. § 1395x(v)(1)(A). Its holding that Medicare is not obligated to share in the indirect costs which a hospital necessarily incurs as a part of its GME program means that these costs inevitably will be improperly shifted to non-Medicare beneficiaries.

Finally, the Third Circuit erroneously held that a failure to claim reimbursement for these indirect costs in the past creates an irrebuttable presumption that these costs have been absorbed by the community. This holding quite simply has no basis in law. In addition, it would permit the Secretary to act in an arbitrary and capricious fashion, perhaps even violating due process, by simply ignoring any relevant or even substantial evidence to the contrary.

In contrast to the decision of the Third Circuit in this case, the Sixth Circuit Court of Appeals has correctly recognized that the same indirect costs at issue here are allowable. The Sixth Circuit's approval is not only consistent with the language of 42 C.F.R. § 413.85, but also is consistent with the Medicare Act's prohibition against cost-shifting and other relevant Medicare regulations. *See Ohio State University v. Secretary, DHHS*, 777 F. Supp. 582 (S.D. Ohio 1991), *aff'd*, 996 F.2d 122 (6th Cir.), *petition for cert. filed*, 62 U.S.L.W. 3399 (U.S. Nov. 1, 1993) (No. 93-696). The Court should adopt the Sixth Circuit's proper interpretation and application of federal Medicare law as its own rule of decision in this case.

ARGUMENT

The overhead costs of graduate medical education programs are costs incurred by every teaching hospital that conducts a GME program.[1] They are costs that the Secretary recognizes are properly recoverable by a "stand

[1] These costs generally consist of allocated administrative costs (indirect costs allocated to clinical departments and not duplicative of university overhead allocated to the hospital); salary and fringe benefit costs of professional non-physician working staff (business office managers, programmers who support faculty members, etc.); salary and fringe benefit costs of clerical personnel and secretaries who work for the faculty members and professional staffs; space costs (depreciation, utilities, and related costs of offices and support areas used by faculty members) allocated on a square footage basis; and expenses for supplies that are consumed by the clinical departments of the educational unit.

alone" teaching hospital, that is, one that operates its GME program with its own teaching staff and resources. *Ohio State University*, 777 F. Supp. at 588-89. Yet the Secretary unjustifiably seeks to deny reimbursement for these same costs to teaching hospitals whose GME programs are conducted through colleges of medicine, the majority of which are State institutions.[2] The Secretary has claimed, and the Third Circuit has found, that permitting recovery of these costs would provide an impermissible benefit to a college of medicine rather than a proper reimbursement for the allowable costs of the teaching hospital. This position lacks merit in fact and in law.

Acceptance of the Secretary's position results in discriminatory treatment of teaching hospitals that operate their GME programs through related educational facilities. As the Secretary fully understands, this position has a particular adverse effect on State university hospitals that have traditionally conducted their GME programs through existing educational units of the university.

42 C.F.R. §§ 413.85 and 413.17[3] mandate that a hospital be reimbursed its reasonable direct and indirect costs

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[2] In response to the petition for writ of certiorari, the Secretary recognizes that the current issue affects approximately 17 hospitals – 10 of which are State university teaching hospitals. Brief of Respondent on Petition for Writ of Certiorari at 10-11.

[3] The Medicare "reasonable cost" regulations were originally codified at 20 C.F.R. Pt. 405 (1967). They have been redesignated twice – first at 42 C.F.R. Pt. 405 (1977), *see* 42 Fed. Reg. 52,826 (1977), and most recently at 42 C.F.R. Pt. 413 (1986), *see* 51 Fed. Reg. 34,790 (1986). Neither redesignation affects the substance of the regulations at issue in this case, and the amici will refer to the regulations as currently codified.

with respect to the provision of patient care services as part of the hospital's educational activities. Contrary to the arguments advanced by the Secretary, and as discussed further *infra*, the definition of reasonable costs of educational activities provided in Medicare law establishes that State subsidies, grants, and donations do not constitute "community support" of the hospital's educational program such as to preclude reimbursement by the Medicare program of its fair share of these costs. Nor do the facts that these costs were initially incurred by a college of medicine on behalf of the provider, or that they were inadvertently not claimed in the past, reflect "community support" of the provider's educational program or an improper "redistribution" of costs from an educational unit to a patient care unit. Rather, recovery of the GME overhead costs at issue in this case is consistent with the plain language of the applicable regulations, their history, and existing statutory and case law, including the recent decision of the Sixth Circuit in *Ohio State University, supra*.

I. TRADITIONAL UNIVERSITY FUNDING DOES NOT CONSTITUTE "COMMUNITY SUPPORT" SO AS TO PRECLUDE MEDICARE PARTICIPATION IN A TEACHING HOSPITAL'S GME PROGRAM

42 C.F.R. § 413.85(c) and (g) recognize Medicare's obligation to participate in GME programs. These regulations provide, in part, as follows:[4]

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[4] The final sentence of section (c), referred to as the "redistribution principle," has not been quoted. Rather, it has been set out and discussed in Section II of this brief.

(c) Many providers engage in educational activities including training programs for nurses, medical students, interns and residents, and various paramedical specialties. These programs contribute to the quality of patient care within an institution and are necessary to meet the community's need for medical and paramedical personnel. It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. *Until communities undertake to bear these costs, the program will participate appropriately in the support of these activities.* . . .

(g) Net costs of approved educational activities are determined by deducting, from a provider's total costs of these activities, revenues it receives from tuition. For this purpose, *a provider's total costs include trainee stipends, compensation of teachers, and other direct and indirect costs of the activities* as determined under Medicare cost-finding principles. . . . (emphasis added)

The Third Circuit's judgment would allow the Secretary to deny Medicare reimbursement to State-funded teaching hospitals for undisputedly allowable indirect costs of their GME programs. It does so by accepting the Secretary's argument that prior State funding constitutes proof that the community has already assumed responsibility for these costs.[5] "In essence, the Secretary's decision interprets community support as any source of

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[5] The direct costs of the GME programs, such as compensation to teaching physicians, that have been incurred by teaching hospitals through colleges of medicine have been considered allowable costs and have been reimbursed by the Medicare program despite the fact of State funding. *Ohio State University v. Secretary, DHHS*, 777 F. Supp. 582, 588 (S.D. Ohio 1991), *aff'd*, 996 F.2d 122 (6th Cir.), *petition for cert. filed*, 62 U.S.L.W. 3399 (U.S. Nov. 1, 1993) (No. 93-696); *Thomas Jefferson v. Shalala*, No. 93-120 (U.S. filed July 20, 1993), *petition for writ of cert.*, app. at 11a, n.5; *The Board of Regents of the University of Minn. d/b/a University of Minn. Hosp. and Clinic v. Shalala*, 837 F.Supp 303 (D. Minn. 1993). In initially denying teaching hospitals claims for indirect costs, the Secretary stated that the basis for the denial was that direct costs were recoverable but that "indirect" costs were not. *In the Case of: Thomas Jefferson University*, Decision of the Administrator (Nov. 17, 1989), as cited in *Thomas Jefferson University v. Shalala*, No. 93-120 (U.S. filed July 20, 1993), petition for writ of cert., app. at 36a; *In the Case of: Ohio State University*, Decision of the Administrator, Medicare & Medicaid Guide (CCH) Para. 38,907 at 24,369 (Oct. 15, 1990); *In the Case of: University of Minn.*, Medicare & Medicaid Guide (CCH) Para. 39,420 at 26,829 (May 29, 1991). Perhaps recognizing that this argument lacked any support in Medicare law, the Secretary has not asserted it at the judicial level. *See* Secretary's Petition for Writ of Certiorari in *Ohio State University v. Shalala*, No. 93-696 (U.S. filed Nov. 1, 1993) at 6, n.5 and question presented in Respondent's Brief in response to petition for writ of certiorari in *Thomas Jefferson; see also Ohio State University v. Secretary, DHHS*, 996 F.2d at 124 ("The plain meaning of 42 C.F.R. § 413.85(c) is to authorize reimbursement of all direct and indirect costs. . . . ").

funding other than the Medicare program." *In the Case of: Thomas Jefferson University*, Medicare & Medicaid Guide (CCH) Para. 40,294 at 30,964, (E.D.Pa. May 1, 1992), *aff'd without opinion*, No. 92-1513 (3rd Cir.), *cert. granted*, 62 U.S.L.W. 3451 (U.S. July 20, 1993) (No. 93-120). This interpretation, however, is contrary to law, inappropriately penalizes a select number of university affiliated teaching

hospitals, and is inconsistent with the Secretary's treatment of other GME program costs.

A. Neither the Language of 42 C.F.R. § 413.85 Nor Its History Justifies Defining the Term "Community Support" to Mean State Subsidies, Grants, or Donations

There is nothing in the language or background of 42 C.F.R. § 413.85 to support an argument that the types of institutional funding ordinarily received by a university teaching hospital – such as State subsidies, grants, and donations – constitutes "community support" of the hospital's GME program so as to preclude the hospital from being able to include its GME overhead costs as allowable costs for purposes of Medicare reimbursement. On the contrary, 42 C.F.R. § 413.85(c) recognizes that many Medicare providers engage in educational activities and incur the costs related to those activities. The regulation states that although the costs of educational activities should be borne by the community rather than the teaching hospital, Medicare will pay its fair share of the costs incurred by the teaching hospital until the community assumes responsibility for them. The costs incurred in this case are costs incurred by the teaching hospital and not costs borne by the community.

42 C.F.R. § 413.85(c) does not define the term "community support," does not provide a mechanism for the offset of community support, and does not provide a mechanism for identifying sources of community support or for measuring the amount given. In contrast, section

(g) of the same regulation specifically provides the formula for calculating allowable costs of educational programs. That formula starts with the inclusion of the total direct and indirect costs of the educational programs and then deducts from total costs only the revenues received from tuition. As explained, *infra*, prior versions of 42 C.F.R. § 413.85(g) also had deducted from total direct and indirect educational costs the revenues received from grants and donations. These deductions, however, were eliminated by amendment to § 413.85(g) prior to the cost reporting period in question. Clearly, if "community support" was also intended to be offset, the regulation would provide comparable language.

The history of the regulation does not support the offset of grants, donations and State subsidies. As originally enacted, 42 C.F.R. § 405.421(b)(2) provided that net allowable educational costs were determined by deducting grants, tuition, and specific donations from the cost of approved educational activities. By amendment dated August 5, 1980, this section was revised (and redesignated paragraph (g)), to eliminate the deduction for certain donations for internships and residency programs. 45 Fed. Reg. 51,783 at 51,786 (1980). By amendment dated January 3, 1984, the deduction of grants and certain donations was eliminated in its entirety. 49 Fed. Reg. 234 at 296 (1984). These deletions clearly indicate that such funds are *not* to be offset in determining those costs which are properly reimbursable.

Unrestricted State subsidies have always been exempt from offset against allowable educational costs:

> Whether or not they are characterized as a 'grant' or 'gift,' funds transferred to a provider from another component of the same organizational entity – e.g., from a university to the university hospital or from a State agency to a State university hospital – are not considered a grant or gift for Medicare reimbursement purposes but rather an internal transaction amounting only to self-financing of the entity's own component operations, thus having no effect on the provider's allowable costs. . . .

Section 607, Provider Reimbursement Manual. Thus, the Third Circuit's decision that "community support" can be defined to include State subsidies is plainly incorrect.[6] This supposed basis for denying allowable indirect costs of GME programs is inconsistent with both 42 C.F.R. § 413.85 and the governing Medicare program instructions.

The reason for subsequently exempting restricted grants and State subsidies from offset as of October, 1983 was clearly set forth in the preamble to the revision:

> Since the offset of donor restricted contributions appears to dilute the effect of the contribution, it may discourage private philanthropy. Because we believe it is in the best interests of needed health care to increase private sector support of

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[6] State subsidies are often necessary to support State-teaching hospitals because of the disproportionate level of indigent care provided in such institutions. In the absence of State subsidies, the revenues received from patients with insurance coverage (including Medicare) and independent resources would be insufficient to cover the costs of operating the teaching program.

> health care institutions, we are eliminating Sec. 405.423 [which required the offset of restricted grants, gifts and income from endowments]. As a result, restricted grants and gifts will no longer be used to offset costs effective with cost reporting periods beginning on or after October 1, 1983.

48 Fed. Reg. 39,752 at 39,797 (1983).

Until the current dispute, the Secretary had consistently followed the position of not offsetting State subsidies and grants against GME costs, as is evident from the regulation's more recent history. In September of 1989, in response to concerns about whether medical schools, which were adequately funded by grants from State and local governments, should be permitted to pass through their GME costs to the hospital, the Secretary stated:

> With respect to the comment that we should address the issue of funding that covers the costs of operating the medical school, our policy prior to October 1, 1983 provided that restricted grants . . . were deducted from the designated costs incurred by the provider. Unrestricted contributions, however, would not be deducted from such costs. Section 901 of the Omnibus Budget Reconciliation Act of 1980 (Pub. L. 96-499) added section 1134 of the Act. This provision affirmed the Secretary's authority not to offset donor-restricted grants and gifts that the Secretary finds, in the best interests of needed health care, should be encouraged. The policy that restricted grants could be offset against allowable costs incurred by providers was changed effective October 1, 1983. . . .

> Thereafter, any grant monies received by a provider could not be offset against the reimbursable amounts due the provider under Medicare.

54 Fed. Reg. 40,286 at 40,302 (1989).

Based upon the above, it is clear that traditional funding received by teaching hospitals is not to be offset against allowable costs. Further, it is undisputed that these types of funding have historically not acted as a bar to the recovery of the direct costs of a teaching hospital's approved GME program. *See supra* note 5. Thus, the Secretary's claim in this case that this traditional funding establishes that the community has undertaken responsibility for the GME overhead costs at issue is both novel and wrong, and her decision to deny Medicare reimbursement for such costs is not only without legal justification but also is internally inconsistent.[7] Despite these facts, and without any explanation as to how any such imaginary distinctions can be made, the Third Circuit incorrectly held that the Secretary's position permitting offset is "reasonable." *Thomas Jefferson*, Medicare & Medicaid Guide (CCH) Para. 40,294 at 30,965.

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[7] Even in light of the Secretary's arbitrary position, factual differences may arise with respect to the various cases that are currently pending on this issue before this Court and the lower federal court. For example, the Secretary specifically relied upon the "community support" principle in *Thomas Jefferson*. The Secretary specifically did not rely upon the "community support" principle in *Ohio State University, supra*, a case in which State funding is limited to an unrestricted State subsidy. Even if the Court was to find any merit in the Secretary's position, therefore, differences such as this reflect the importance of the Court at least creating a standard that allows each case to be judged in light of its individual facts.

B. The Secretary's Interpretation of the Meaning of "Community Support" as Set Forth in 42 C.F.R. § 413.85(c) Violates 42 U.S.C. § 1395x(v)(1)(A)

The Third Circuit's interpretation of the "community support" language of 42 C.F.R. § 413.85(c) as a means of avoiding Medicare's participation in patient-related educational programs contravenes fundamental statutory principles of Medicare law. 42 U.S.C. § 1395x(v)(1)(A) provides that "the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered." This statute specifically prohibits the direct and indirect costs of delivering health care services to Medicare beneficiaries from being shifted away from Medicare beneficiaries and being imposed instead on non-Medicare beneficiaries.

As recognized in 42 C.F.R. § 413.85(c), GME training affords benefits to both Medicare and non-Medicare patients in terms of enhanced quality of care. Medicare reimbursement for the indirect costs associated with graduate medical training, which benefits Medicare patients directly, is necessary to properly allocate the cost of such training between Medicare and non-Medicare beneficiaries consistent with 42 U.S.C. § 1395x(v)(1)(A). The Secretary's disallowance of these costs necessarily shifts these costs improperly onto non-Medicare beneficiaries:

> By reimbursing the Hospital for the portion of clinic training which the residents receive and pass on to their Hospital Medicare patients in terms of enhanced quality of service, costs are *properly* shifted to the patient care institution

> and its Medicare beneficiaries. This comports with the underlying statute, 42 U.S.C. § 1395x(v)(1)(A), which prohibits shifting necessary *direct or indirect costs* of providing services from Medicare beneficiaries to non-Medicare beneficiaries. . . . The Hospital seeks only reimbursement for the *allocable* share of costs, *i.e.*, the costs equal to the proportion of Medicare patients at the Hospital relative to the Hospital population. *See* 42 C.F.R. § 405.402(a) (1982) (emphasis added).

University of Cincinnati v. Bowen, 875 F.2d 1207, 1210 (6th Cir. 1989). *See also St. John's Hickey Memorial Hosp. v. Califano*, 599 F.2d 803, 807 (7th Cir. 1979) (finding Secretary's community support position in contravention of cost-shifting principle given that clear weight of evidence established that the provider was not the recipient of community-supported financing for a nursing education program operated by the provider in conjunction with a local educational institution); *Los Alamitos General Hosp. v. Donnelly*, 558 F. Supp. 1141, 1145 (D.D.C. 1983) (finding that since nursing services are provided to both Medicare and non-Medicare patients, disallowance of the costs of the nursing program would violate 42 U.S.C. § 1395x(v)(1)(A)).

Accordingly, in an attempt to avoid Medicare reimbursement of allowable GME overhead costs, the Third Circuit has erroneously interpreted the term "community support" as set forth in 42 C.F.R. § 413.85(c). The Third Circuit's interpretation is not only inconsistent with the plain language of the regulation and the Secretary's past interpretation of what constitutes net costs, but also violates Medicare's cost-shifting principle as set forth in 42 U.S.C. § 1395x(v)(1)(A).

II. THE REDISTRIBUTION PRINCIPLE DOES NOT SUPPORT THE DENIAL OF MEDICARE PARTICIPATION TO THOSE EDUCATIONAL *ACTIVITIES* WHICH ARE CUSTOMARILY OR TRADITIONALLY CARRIED ON BY TEACHING HOSPITALS IN CONJUNCTION WITH THEIR GME PROGRAMS

42 C.F.R. § 413.85(c) not only recognizes the importance of Medicare participation in educational activities but also recognizes the importance of limiting Medicare participation to those educational activities which are a customary part of a hospital's teaching program. This concept is referred to as the "redistribution principle" and is set forth in the final sentence of 42 C.F.R. § 413.85(c) as follows:

> Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

The plain meaning of this language "is to allow providers to receive reimbursement for a fair share of all direct and indirect costs related to educational activities customarily or traditionally carried on by providers in conjunction with their operations." *Ohio State University*, 996 F.2d at 124.

Teaching hospitals traditionally and customarily engage in the clinical training of interns and residents in

the hospital setting, as well as training programs involving other health care occupations such as nursing, occupational therapy, pharmacy, physical therapy, and x-ray technology. In contrast, educational institutions customarily engage in classroom training, undergraduate medical education, or other nonclinical educational activities. As the district court recognized in *Ohio State University*, the "activities customarily or traditionally carried on by providers" includes such clinical training programs for interns and residents:

> In the case of graduate medical education, it would be customary and traditional for a teaching hospital to employ qualified physicians in various medical specialties to select and supervise the interns and residents enrolled in the educational program. These physicians would need clerical and administrative staff, office space and supplies to carry out their function. Their salaries, the salaries of their clerical and administrative staffs, and the cost of their office space and supplies would all be part of the cost of the educational activity which ultimately contributes to the quality of patient care in the hospital. . . . These would be the kind of costs Congress intended that the Medicare program should participate in.

Ohio State University, 777 F. Supp. at 587.

Under this straightforward interpretation of the redistribution principle, such costs should be disallowed only when it is shown that the costs for which reimbursement was claimed included those purely for educational institutions unrelated to patient care. *Id.* In contrast, when the evidence establishes that such costs are related

to providing patient care, then they are not an improper redistribution. Rather, they are "reimbursable under 42 U.S.C. § 1395hh and 42 C.F.R. § 413.85(g), which allow recovery of costs of providers of medical services relating to patient care." *Ohio State University*, 996 F.2d at 125.

The Third Circuit's decision has wrongly interpreted this provision to mean that if GME overhead costs are incurred by a college of medicine as part of a hospital's GME program and have not been previously claimed by the hospital as an allowable cost, then an irrebuttable presumption arises that the community has undertaken responsibility for these costs. Continuing with this analysis, the Secretary argues that to permit the provider to recover these costs now would result in an inappropriate "redistribution" of costs from the community to the Medicare program. *See* Brief in Opposition to Petition for Writ of Certiorari at 8-9.

As discussed below, the Secretary's argument is inconsistent with the Secretary's prior reimbursement of direct costs, contravenes the plain language of 42 C.F.R. § 413.85, and is arbitrary and capricious. This Court should not adopt the Third Circuit's error in blindly accepting the proposition that costs incurred by a college of medicine in operating a hospital's GME program constitutes costs of the "community" for purposes of 42 C.F.R. § 413.85(c)'s redistribution principle.

A. 42 C.F.R. § 413.17 Permits a Provider to Recover Allowable Direct and Indirect Costs Incurred by a Related Entity for Services, Facilities, and Supplies Furnished to the Provider

42 C.F.R. § 413.17 provides:

> (a) Except as provided in paragraph (d) of this section, *costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization.* However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.
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> * * *
>
> (c)(2) If the provider obtains items of services, facilities, or supplies from an organization, even though it is a separate legal entity, and the organization is owned or controlled by the owner(s) of the provider, *in effect the items are obtained from itself. . . . Therefore, reimbursable cost should include the costs for these items at the cost to the supplying organization.* (emphasis added)

This provision, referred to as the "related party principle," expressly authorizes Medicare reimbursement for the costs of services, facilities, and supplies furnished to a provider by any organization related to the provider by common ownership or control. This principle simply recognizes that there is, in reality, only one organization. The purpose of this regulation is to ensure that the amounts

claimed for reimbursement are limited to the specific costs incurred by the related organization.[7]

The Secretary historically has not contested the applicability of this principle to the *direct* costs of a teaching hospital's GME program that are incurred by a related college of medicine. Rather, the Secretary has routinely provided reimbursement for allowable direct costs claimed on behalf of a related entity.[8] *See supra* note 5.

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[7] For example, in *Ohio State University*, although the Medicare regulations do not require transfers of funds between related entities, the hospital does transfer funds to the college of medicine as part of the hospital's bookkeeping procedures. *See* 777 F. Supp. at 585. Because the entities are related, however, the hospital cannot claim the entire amount of the transfer as an allowable Medicare cost. Rather, the hospital can claim only the specific costs incurred by the college of medicine in operating the hospital's GME program.

[8] The shifting nature of the Secretary's position raises serious due process concerns. For example, in *Ohio State University, supra*, the intermediary recognized the GME overhead costs as costs of the hospital and did not deny reimbursement on the basis that they had been incurred by a related entity. Rather, the intermediary's position was that a failure to claim the costs in the past constituted an absolute bar to claiming such costs now. The Administrator, without any discussion of the related party principle, disallowed the costs on the basis that they were (a) community-supported educational costs, and (b) indirect costs. Accordingly, if the Court were to find any legal basis for setting aside the related party principle in the isolated instance of a provider seeking to recover indirect costs which had not been claimed in the past, the Court should further consider whether the hospitals so affected should be given the opportunity to offer proof about responsibility for these costs (such as by way of internal transfers or through continued GME program financial deficits) in order to have the opportunity to defeat any erroneous "presumption" of community support.

Nor is there any language in either 42 C.F.R. § 413.17 or 42 C.F.R. § 413.85 which provides for a distinction between direct costs and the kinds of indirect costs which are presented in this case. Instead, 42 C.F.R. § 413.85(g) expressly authorizes reimbursement of the indirect costs which are at issue here:

> (g) Calculating net costs. Net costs of approved educational activities are determined by deducting, from a provider's total costs of these activities, revenues it receives from tuition. For this purpose, a provider's total costs include trainee stipends, compensation of teachers, *and other direct and indirect costs of the activities* as determined under the Medicare cost-finding principles in § 413.453. (emphasis added)

As the Sixth Circuit correctly held in *University of Cincinnati*: "The costs of approved educational activities, such as stipends paid to residents *and related overhead*, are ordinarily included as reasonable costs." 875 F.2d at 1208 (emphasis added); *see also Ohio State University*, 777 F. Supp. at 588 ("Clearly, both direct and indirect costs of approved educational activities are reimbursable under § 413.85(g). It makes no sense to say that direct costs are reimbursable if incurred by a provider or a related medical school but that indirect costs are reimbursable only if incurred by the provider.")

Accordingly, the governing law dictates that reimbursement is to be made whenever a teaching hospital establishes these controlling facts:

> (1) the medical school is a related entity,
>
> (2) the Secretary has approved reimbursement for the direct costs of the GME program provided by the medical school, and
>
> (3) the indirect costs being sought are the same as would be allowed by a stand-alone community hospital.

Under these clear standards, there is no basis in law for denying such reimbursement in this case.

B. A Mistaken Failure to Claim Allowable Costs in the Past Cannot Constitute an Absolute Bar to Claiming Such Costs in the Future

The Secretary has taken the extrastatutory position that the related party principle is to be set aside in the isolated instance of a teaching hospital seeking to recover the indirect costs of its GME program where the hospital conducts its program through a college of medicine and has not sought Medicare reimbursement of these costs in the past. The Secretary's position is based upon a presumption that the failure to claim these costs in the past, regardless of the reason, absolutely proves that the "community" has supported the GME program,[9] and that to

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[9] Such an argument places a provider in the extremely difficult task of proving a negative. It is comparable to saying that because an individual failed to claim a business deduction in the past, the individual did not personally incur the expense. Thereafter, the individual will be barred from subsequently amending the income tax return in question unless the individual can prove that no one else paid the expense, with the added imposition that a receipt and statement that the expense was

permit reimbursement would result in an improper "redistribution" of costs. The Third Circuit accepted the Secretary's position because it mistakenly perceived a conflict between the related party principle of 42 C.F.R. § 413.17 and the redistribution principle of 42 C.F.R. § 413.85. Yet the Third Circuit's misinterpretation of the related party principle lacks legal authority, distorts the plain language of the redistribution principle, and violates basic principles of Medicare law.

1. The Secretary Cannot be Permitted to Arbitrarily Refuse to Consider Evidence

Federal courts have consistently held that there is no basis in law for the Secretary to refuse to consider Medicare reimbursement of previously unreported GME program costs despite evidence explaining the prior failure to claim such costs. "Where a provider gives a legitimate explanation for its failure to report or claim the costs in prior years, a refusal to consider the allowability of the costs is arbitrary and capricious." *Ohio State University*, 777 F. Supp. at 588.

For example, in *St. John's Hickey Memorial Hosp., supra*, the hospital had initiated a joint nursing education program with an unrelated local college. The intermediary disallowed the hospital's portion of the costs, stating that they had been borne by the "community" and would therefore constitute a redistribution. The PRRB rejected the intermediary's argument and held that the costs were

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individually incurred will always be judged as insufficient proof of the point.

reimbursable. The Administrator, as in the present case, reversed on the ground that the program was community supported. In reversing the Administrator, the Seventh Circuit Court of Appeals stated:

> The Secretary's conclusion that the program costs were unnecessary appears to be based solely on the theory that once a non-provider becomes the legal operator of the program, this establishes that the community has undertaken the costs of nursing education, so that it is unnecessary for the provider to continue to bear them. This theory is plainly contrary to the facts of the present case.

St. John's Hickey Memorial Hosp., 599 F.2d at 811 (citations omitted).

The same concerns were echoed by the Ninth Circuit in *Mercy Hosp. & Medical Center, San Diego v. Harris*, 625 F.2d 905 (9th Cir. 1980). In that case, a hospital sought partial reimbursement of deficits arising from the operation of an outpatient clinic on the basis that it constituted an educational activity. The Secretary had taken the position that the mere presence of patients constituted an absolute bar to being able to prove that the activity could qualify as an educational program. The Ninth Circuit disagreed: "A proper interpretation of HIM-15 . . . should allow a hospital to avoid the apparent bar to allocating such costs as educational costs upon a showing that the patient care activities involved are primarily dictated by the objectives of an overriding educational program. The Secretary's failure to allow for such a showing is arbitrary." *Id.* at 909.

A failure to permit a teaching hospital affiliated with a medical school to claim allowable costs simply because the hospital mistakenly failed to claim such costs in the past constitutes an arbitrary refusal on the part of the Secretary to consider evidence and to permit recovery on the basis of such evidence. It simply finds no basis in Medicare law.

2. The Third Circuit's Interpretation of the Redistribution Principle is Inconsistent with Basic Rules of Statutory Construction

It is a basic rule of statutory construction that every effort should be made to reconcile legislative enactments rather than to find that they are in conflict. *See, e.g., Connecticut National Bank v. Germain*, ___ U.S. ___, 112 S. Ct. 1146, 60 U.S.L.W. 4222, 4223 (1992) (as long as there is no "positive repugnancy" between two laws, a court must give effect to both); *Negonsott v. Samuels*, 933 F.2d 818, 819 (10th Cir. 1991), *aff'd*, 113 S. Ct. 1119 (1993) (statutes should be construed so that their provisions are harmonious with each other); *United States of America v. Caldera-Herrera*, 930 F.2d 409, 411 (5th Cir. 1991) (statutes must be read in harmony with one another so as to give meaning to each provision).

In the present case, the related party principle (42 C.F.R. § 413.17) and the redistribution principle (42 C.F.R. § 413.85) are readily reconcilable. Indeed, it is only by misconstruing the plain intent of the redistribution principle that the Third Circuit managed to hypothesize a conflict between them.

Recognizing that related parties are, in essence, a single entity, the related party principle permits a hospital to recover the *allowable* costs of services, facilities, and supplies furnished to the hospital by a related party and limits the amount of that recovery to the specific costs incurred by the related party. At the same time, the effect of the redistribution principle is to permit

> . . . reimbursement of all direct and indirect costs related to the kinds of educational activities customarily or traditionally carried on by providers, but to deny reimbursement for costs related to educational activities which are customarily or traditionally carried on by educational institutions, such as medical and nursing schools.

Ohio State University, 996 F.2d at 124.

As such, the redistribution principle makes it quite clear that allowable costs are *only* those educational costs related to patient care at the hospital. Medicare will not participate in costs unrelated to patient care, such as undergraduate instruction or other activities which are not customarily and traditionally carried on by providers. Interpreted in this manner, the redistribution principle is not only entirely consistent with and complimentary to the related party principle, but it also is consistent with 42 U.S.C. § 1395x(v)(1)(A), which prohibits providers from shifting the necessary direct and indirect costs of delivering health care services from Medicare beneficiaries to non-Medicare beneficiaries.

The Third Circuit's approach, which ignores the plain language of the redistribution principle "to share in the

support of educational activities customarily or traditionally carried on by providers in conjunction with their operations," unnecessarily and incorrectly places that principle in conflict with the related party principle and in conflict with Medicare's underlying cost-shifting principle. That misreading of Medicare law should not be approved by this Court. "The traditional deference courts pay to agency interpretation is not to be applied to alter the clearly expressed intent of Congress." *K Mart Corp. v. Cartier, Inc.*, 486 U.S. 281, 291 (1988).

CONCLUSION

In order for educational activities to be reimbursable under the "plain language" of the Medicare regulations, they must:

> (1) be approved programs; (2) contribute to the quality of patient care within an institution; and (3) not redistribute costs from educational to patient care institutions.

University of Cincinnati, 875 F.2d at 1210.

A State university teaching hospital typically conducts its graduate medical education program by use of existing educational facilities and staff. Because it is an instrumentality of the State, the hospital obviously receives a portion of its funding from the State.[10]

[10] The State university teaching hospital is but one of many components of the State university system, the same as the college of medicine, the college of arts and sciences, the college of veterinary medicine, or the college of business administration. In the case of Ohio State University Hospitals, for example, the college of medicine is located in a building which is contiguous to the Hospital. In the case of the University of Minnesota, to give a different example, the college of medicine is located in the same building as the hospital but on a different floor.

The Secretary's argument that traditional sources of university funding bar State universities and those provider programs which work in conjunction with them from recovering what would otherwise be allowable Medicare costs would unfairly penalize these providers. The Secretary's further argument that the educational component of a single university will be treated as an independent source of community support, solely for purposes of assessing whether GME overhead costs will be reimbursable, would preclude university teaching hospitals from receiving the very same reimbursement that is routinely received by stand-alone community hospitals. These arguments have no basis in Medicare law, and the attempt to create these bars to recovery in a post hoc fashion not only constitutes arbitrary and capricious behavior by the Secretary but violates basic notions of due process.

Based upon the above, the amici curiae respectfully urge this Court to reverse the decision of the Court of Appeals for the Third Circuit in this case. Instead, the Court should embrace the proper and lawful approach adopted by the Court of Appeals for the Sixth Circuit in *Ohio State University, supra*, and hold that Medicare law requires the Secretary to pay a fair share of the

direct and indirect costs of the GME programs of teaching hospitals consistent with 42 C.F.R. §§ 413.85 and 413.17.

Respectfully submitted,

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APPENDIX

42 U.S.C. § 1395x

(v) Reasonable costs

(1)(A) The reasonable cost of any services shall be the cost actually incurred, excluding there from any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types of classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs

necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

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42 C.F.R. § 413.85
Formerly. . . .
42 C.F.R. § 405.421

§ 413.85 Cost of educational activities.

* * *

(b) *Definition – Approved educational activities.* Approved educational activities means formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution. These activities must be licensed if required by State law. If licensing is not required, the institution must receive approval from the recognized national professional organization for the particular activity.

(c) *Educational activities.* Many providers engage in educational activities including training programs for nurses, medical students, interns and residents, and various paramedical specialties. These programs contribute to the quality of patient care within an institution and are necessary to meet the community's needs for medical and paramedical personnel. It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the program will participate appropriately in the support of these activities. Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended

that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

(d) *Activities not within the scope of this principle.* The costs of the following activities are not within the scope of this principle but are recognized as normal operating costs and are reimbursed in accordance with applicable principles –

(1) Orientation and on-the-job training;

(2) Part-time education for bona fide employees at properly accredited academic or technical institutions (including other providers) devoted to undergraduate or graduate work;

(3) Costs, including associated travel expense, of sending employees to educational seminars and workshops which increase the quality of medical care or operating efficiency of the provider;

(4) Maintenance of a medical library;

(5) Training of a patient or patient's family in the use of medical appliances;

(6) Clinical training of students not enrolled in an approved education program operated by the provider; and

(7) Other activities that do not involve the actual operation of an approved education program including the costs of interns and residents in anesthesiology who are employed to replace anesthetists.

(e) *Approved programs.* In addition to approved medical, osteopathic, dental, and podiatry internships and

residency programs, recognized professional and paramedical educational and training programs now being conducted by provider institutions, and their approving bodies, include the following:

(f) *Other educational programs.* There may also be other educational programs not included in the foregoing in which a provider institution is engaged. Appropriate consideration will be given by the intermediary and the Health Care Financing Administration to the costs incurred for those activities that come within the purview of the principle when determining the allowable costs for apportionment under the health insurance program.

(g) *Calculating net cost.* Net costs of approved educational activities are determined by deducting, from a provider's total costs of these activities, revenues it receives from tuition. For this purpose, a provider's total costs include trainee stipends, compensation of teachers, and other direct and indirect costs of the activities as determined under the Medicare cost-finding principles in § 405.453.

(Secs. 1102 and 1371 of the Social Security Act (42 U.S.C. 1302 and 1396hh))

42 C.F.R. § 413.17

§ 413.17 Cost to related organizations.

(a) *Principle.* Except as provided in paragraph (d) of this section, costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

(b) *Definitions* – (1) *Related to the provider.* Related to the provider means that the provider to a significant extent is associated or affiliated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

(2) *Common ownership.* Common ownership exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.

(3) *Control.* Control exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

(c) *Application.* (1) Individuals and organizations associate with others for various reasons and by various means. Some deem it appropriate to do so to assure a steady flow of supplies or services, to reduce competition, to gain a tax advantage, to extend influence, and for other reasons. These goals may be accomplished by

means of ownership or control, by financial assistance, by management assistance, and other ways.

(2) If the provider obtains items of services, facilities, or supplies from an organization, even though it is a separate legal entity, and the organization is owned or controlled by the owner(s) of the provider, in effect the items are obtained from itself. An example would be a corporation building a hospital or a nursing home and then leasing it to another corporation controlled by the owner. Therefore, reimbursable cost should include the costs for these items at the cost to the supplying organization. However, if the price in the open market for comparable services, facilities, or supplies is lower than the cost to the supplier, the allowable cost to the provider may not exceed the market price.

(d) *Exception.* (1) An exception is provided to this general principle if the provider demonstrates by convincing evidence to the satisfaction of the fiscal intermediary (or, if the provider has not nominated a fiscal intermediary, HCFA), that –

(i) The supplying organization is a bona fide separate organization;

(ii) A substantial part of its business activity of the type carried on with the provider is transacted with others than the provider and organizations related to the supplier by common ownership or control and there is an open, competitive market for the type of services, facilities, or supplies furnished by the organization;

(iii) The services, facilities, or supplies are those that commonly are obtained by institutions such as the

provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions; and

(iv) The charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

(2) In such cases, the charge by the supplier to the provider for such services, facilities, or supplies is allowable as cost.

Federal Register/Vol. 45 No. 152 Tuesday, August 5, 1980

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 405

Medicare Program; Reimbursement for Costs of Approved Internship and Residency Programs

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule.

SUMMARY: This final rule amends the regulation governing Medicare payments to providers of services for their costs of approved educational activities. Under the current regulation, providers are required to deduct all grants designated for specific education programs from their costs of those programs in calculating their costs that are reimbursed by Medicare. Under the amended regulation, providers will not be required to deduct grants for primary care internship and residency program. The rule is intended to avoid nullifying the purposes of specific grants for their programs.

The amended rule will also apply to Medicaid payments in those States that pay for costs of educational activities the same basis as Medicare.

EFFECTIVE DATE: January 1, 1978.

The reporting requirements in this regulation are subject to clearance by the Office of Management and Budget under the Federal Reports Act of 1942, and shall not be effective until that clearance is obtained. The

Department will publish a notice on (60 days after publication) advising the public of the outcome of the OMB review.

FOR FURTHER INFORMATION CONTACT:

William Goeller (301) 597-1802.

SUPPLEMENTARY INFORMATION:

Background

Under Medicare, a provider of services (a hospital, skilled nursing facility or home health agency) is reimbursed on the basis of the costs it incurs in furnishing services to Medicare beneficiaries. Current Medicare regulations specify that, in determining the costs reimbursed under Medicare, the provider may include its net costs of educational activities approved in accordance with the regulations at 42 CFR 405.421. Net cost is currently determined by deducting all grants, tuition, and specific donations from the provider's incurred costs for the educational activity (42 CFR 405.421(b)(2)). However, we have found that these deductions undermine the purpose of grant programs designed to support primary care internship and residency programs. Specifically, the deduction of a grant reduces the provider's costs recognized for Medicare reimbursement, thereby preventing the provider from realizing the full benefit of the grant. We believe this thwarts one of the purposes of title VII of the Public Health Service Act, which is to foster the development of programs designed to train physicians in primary care specialties. Therefore, we have changed the regulation to specify that deductions will not be made for grants and donations received to support these programs.

Instead, if hospital revenues for these programs exceed costs, HCFA will notify grant donors so they may make adjustments if called for. . . .

Application to Medicaid Payments

The amended regulation will apply to Medicaid payments made under State plans that require payment for education costs to be made on the same basis as Medicare. In other States, payments for education costs will continue to be made under the existing State plans.

42 CFR 405.421 is amended by revising paragraph (a), redesignating paragraph (b)(1) as paragraph (b), deleting paragraphs (d)(2) and (b)(3), and adding new paragraphs (g) and (h) to read as follows:

§ 405.421 Cost of educational activities.

(a) A provider's allowable cost may include its net cost of approved educational activities, as calculated under paragraph (g) of this section.

(b) *Definition – Approved educational activities.* Approved educational activities means formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution. These activities must be licensed where required by State law. Where licensing is not required, the institution must receive approval from the recognized national professional organization for the particular activity.

* * *

(g) *Calculating net cost.* (1) Except as specified in paragraph (g)(2) of this section, net costs of approved

educational activities are determined by deducting, from a provider's total costs of these activities, revenues it receives from tuition, and from grants and donations that the donor has designated for the activities. For this purpose a provider's total costs include trainee stipends, compensation of teachers, and other direct and indirect costs of the activities as determined under the Medicare cost-finding principles in § 405.453.

(2) Effective for cost reporting periods beginning on or after January 1, 1978, grants and donations that the donor has designated for internship and residency programs in family medicine, general internal medicine, or general pediatrics are not deducted in calculating net costs.

(h) *Reporting of costs and revenues.* Effective for costs reporting periods beginning on or after January 1, 1978, if a provider has received a grant or donation that the donor has designated for an internship or residency program in family medicine, general internal medicine, or general pediatrics, the following requirements apply:

(1) For each program for which the provider received a grant or donation, the provider shall report to its Medicare intermediary, in the form required by HCFA, the following information:

(i) The total direct and indirect costs the provider incurred for the program, as determined under the Medicare cost-finding principles in § 405.453;

(ii) The total revenues the provider received for the program, including tuition, grants and donations designated for the program, and patient care revenues attributable to the program, as calculated under paragraph (h)(2) of this section;

(iii) The amount of the difference between program costs and program revenues; and

(iv) The name and address of the donor of each grant or donation designated for the program, and the amount given by each donor.

(2) For purposes of the report required under paragraph (h)(1) of this section, the provider shall determine the portion of patient care revenues for each department that is attributable to an internship or residency program based on the ratio of that program's costs allocated to the department under § 405.453 to total costs allocated to the department under § 405.453.

(3) The Medicare intermediary will notify HCFA of the amount of any surplus of program revenues over program costs that a provider reports under paragraph (h)(1) of this section, and of the name and address of each donor that supported the program.

(4) If a provider reports a surplus for a program under paragraph (h)(1) of this section that is equal to or less than the amount of the grant the provider received for the program from the Public Health Service. HCFA will notify the Public Health Service of the amount of the surplus. If the surplus exceeds the amount of the grant the provider received for the program from the Public

Health Service, HCFA will notify the Public Health Service and other donors of the amount of the surplus. If the provider did not receive a Public Health Service grant for the program, HCFA will notify other donors of the amount of the surplus.

(Section 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh) Catalog of Federal Domestic Assistance Program No. 13.773, Medicare - Hospital Insurance)

Dated: July 3, 1980.

Earl M. Collier, Jr.,

Acting Administrator, Health Care Financing Administration.

Approved: July 28, 1980.

Patricia Roberts Harris,

Secretary.

[FR Doc 80-23370 filed 8-4-80. 8 45 am]

BILLING CODE 4110-35-M

Federal Register/Vol. 48 No. 171 Thursday, September 1, 1983

E. Grants, Gifts, and Income From Endowments - § 405.423

Medicare policy concerning the treatment of grants and gifts has been in a state of transition for some time. As a general rule, grants and gifts that have been restricted by the donor to pay for a specific operating cost (or group of costs) have been used to reduce that cost. However, a number of exceptions to the general rule on the treatment of restricted contributions have been administratively established and implemented over time. The exceptions (which represent a liberalization of the rule) have resulted from situations where strict application of the general rule would not yield an equitable or desirable effect. These exceptions have included:

- Seed money grants;
- Deficit financing grants:
- Grants for primary care education programs;
- Contributions which benefit only non-Medicare patients; and
- Capital assets purchased with donated funds.

Except for grants for primary care education programs, the exceptions are not contained in the regulations, although they are being applied by the Medicare intermediaries.

The Omnibus Reconciliation Act of 1980 (Pub. L. 96-499) contained a provision dealing specifically with

hospital philanthropy. Section 901 set out the same general rule pertaining to those contributions which shall not be offset as our regulations contain. In addition, the section reaffirmed the Secretary's authority not to offset those types of donor-restricted grants and gifts which the Secretary finds, in the best interests of needed health care, should be encouraged.

The intent behind the general rule pertaining to restricted contributions is to prevent providers from receiving double payment for a given cost – once from the contribution and once from Medicare – and to permit the Medicare program to derive the same benefit from the contribution as do others. We believe the general rule no longer has a significant impact on Medicare program outlays.

Hospitals are the largest beneficiary of restricted grants and contributions. Under the prospective payment system, the treatment of the grants and contributions for purposes of determining reasonable cost will not affect Medicare reimbursement for impatient operating services.

Since the offset of donor restricted contributions appears to dilute the effect of the contribution, it may discourage private philanthropy. Because we believe it is in the best interests of needed health care to increase private sector support of health care institutions, we are eliminating § 405.423. As a result, restricted grants and gifts will no longer be used to offset costs effective with cost reporting periods beginning on or after October 1, 1983.

Federal Register/Vol. 49, No. 1 Tuesday, January 3, 1984

Comment – One commenter questioned whether paragraphs (g) and (h) of § 405.421, which deal with the treatment of grants and donations, should be removed as the result of the deletion of § 405.423 (Grants, gifts, and income from endowments) in the interim final rule.

Response – We agree that a revision is necessary. We have therefore revised § 405.421 by revising paragraph (g)(1) and removing paragraphs (g)(2) and (h). This change merely makes the regulations consistent with the change that was made in the interim final.

• *Grants, gifts and income from endowments* – Section 405.423 was eliminated effective for cost reporting periods beginning on or after October 1, 1983. As a result, restricted grants and gifts will no longer be used to offset costs. We received several comments commending us for making this change in policy. . . .

Federal Register/Vol. 54, No. 188 Friday, September 29, 1989

Comment: Some commenters expressed concern about treatment of GME costs of a related medical school. One commenter pointed out that, in some complexes, GME activities may take place in space assigned to the medical school, and that it would be unfair to impose a restriction on the location of allowable GME patient care activities in large academic health care centers for reimbursement purposes. Another commenter was concerned that medical schools often are adequately funded by grants from State and local governments, so it seems inappropriate for the medical school under such circumstances to also pass-through such costs to the hospital. In the opinion of the commenter, we should address whether there is a redistribution of GME costs when State appropriations or other funding sources are sufficient to cover the costs of operating the medical school.

Response: We agree that determination of allowable costs of related medical schools can be a complicated matter. We are guided by the general principle that to be allowable at all, the costs must be related to patient care furnished in the hospital, and, to be allowable as a direct GME cost, the costs must be related to the GME program in the hospital. Certain identifiable activities conducted by the faculty of a related medical school, which are necessary for the clinical training function at the hospital, may represent allowable costs for Medicare program purposes. These activities include supervision of interns and residents in activities for which no Part B charge is made and the conducting of rounds and patient care conferences related to hospital patients. To reiterate, services

that are both related to the care and treatment of the hospital's patients and furnished in support of the training of interns and residents meet the requirements for payment.

These items and services must be necessary and directly related to the provision of medical school faculty services in the hospital and may not be duplicative of items and services furnished by the hospital. For example, if the hospital is unable to provide office space or clerical support to the physicians supervising its interns and residents, a portion of those costs that are incurred by the university medical school may be allowable if it can be demonstrated to the satisfaction of the fiscal intermediary that such costs are directly related to the training program of the interns and residents working in the university hospital and are related to the care and treatment of the hospital's patients.

In the past, hospitals have alleged that the related organization principle set forth in § 413.17 requires Medicare to reimburse a hospital for a share of all costs of a medical complex or even of the entire university on the basis that the component entities were indistinguishable from the whole. Our policy concerning related organizations was established to avoid program recognition of costs of a provider for services furnished by a related organization in excess of costs incurred by the related organization, and to avoid payment of artificially inflated costs that might be generated from less than arm's length bargaining. This policy was not intended to expand the range of items and services for which a provider could claim Medicare reimbursement, or to include items and services not specifically related to patient care.

With respect to the comment that we should address the issue of funding that covers the cost of operating the medical school, our policy prior to October 1, 1983 provided that restricted grants (those grants that were designated by the donor for paying certain specified provider costs) were deducted from the designated costs incurred by the provider. Unrestricted contributions, however, would not be deducted from such costs. Section 901 of the Omnibus Budget Reconciliation Act of 1980 (Pub. L. 96-499) added section 1134 of the Act. This provision affirmed the Secretary's authority not to offset donor-restricted grants and gifts that the Secretary finds, in the best interests of needed health care, should be encouraged. The policy that restricted grants could be offset against allowable costs incurred by providers was changed effective October 1, 1983 (as provided in the September 1, 1983 final rule (48 FR 39797)). Thereafter, any grant monies received by a provider could not be offset against the reimbursable amounts due the provider under Medicare.

[¶ 5451] TRANSFER OF FUNDS TO A PROVIDER BY ANOTHER COMPONENT OF THE SAME ENTITY (Prov. Reimb. Man., Part 1, § 607)

Whether or not they are characterized as a "grant" or a "gift", funds transferred to a provider from another component of the same organizational entity – e.g., from a university to the university hospital or from a State agency to a State university hospital – are not considered a grant or gift for Medicare reimbursement purposes but rather an internal transaction amounting only to self-financing of the entity's own component operations, thus having no effect on the provider's allowable costs.

However, such funds are considered a grant or gift subject to the rules in §§ 604 [¶ 5440] and 606 [¶ 5443] where the component from which the funds are received is not one which exercises fiscal control over the provider (e.g., a State health department vis-a-vis a State university hospital under the control of the State board of regents) and the funds could not otherwise legally be transferred to the provider by administrative action to supplement its regular funding (e.g., the funds come from appropriations by a State legislature that may be reallocated to supplement the provider's regular State funding only by further legislative action).

.01 Sources:

As adopted. Trans. No. 89 (June 1974)
